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ABSTRACT

This booklet describes Houston's Systemic Crisis Intervention Program (SCIP), an outpatient-based program for adolescents who have attempted suicide, used during the suicidal crisis period and based on the premise that children need a healthy kin system to serve as a buffer to the all too frequent crises of adolescence. The introduction presents two case studies of adolescents who have attempted suicide and background on the nuclear family's need for a health kin system in order to adapt successfully to major life transitions. The next section discusses current research on what propels youth to suicide and what prevents suicide, highlighting the disrupted kin network of the two adolescents presented earlier. Next, aspects of a healthy functioning kin network which functions as a good suicide deterrent is described. The rationale for the Systemic Crisis Intervention Program is presented. The treatment model, consisting of these parts is discussed: (1) providing an immediate emergency response which serves to maintain family members' anxiety within manageable limits; (2) mobilizing extended family members to become involved in the crisis; and (3) restructuring kin system relationships to provide successful long-term solutions to the current crisis. The effectiveness of the program was examined using 47 adolescents accepted for treatment and the results of the evaluation are discussed which showed that during the follow-up period of more than one year only two subjects engaged in suicidal behavior, neither of which resulted in physical harm, and that family and marital functioning improved during the treatment phase. (ABL)

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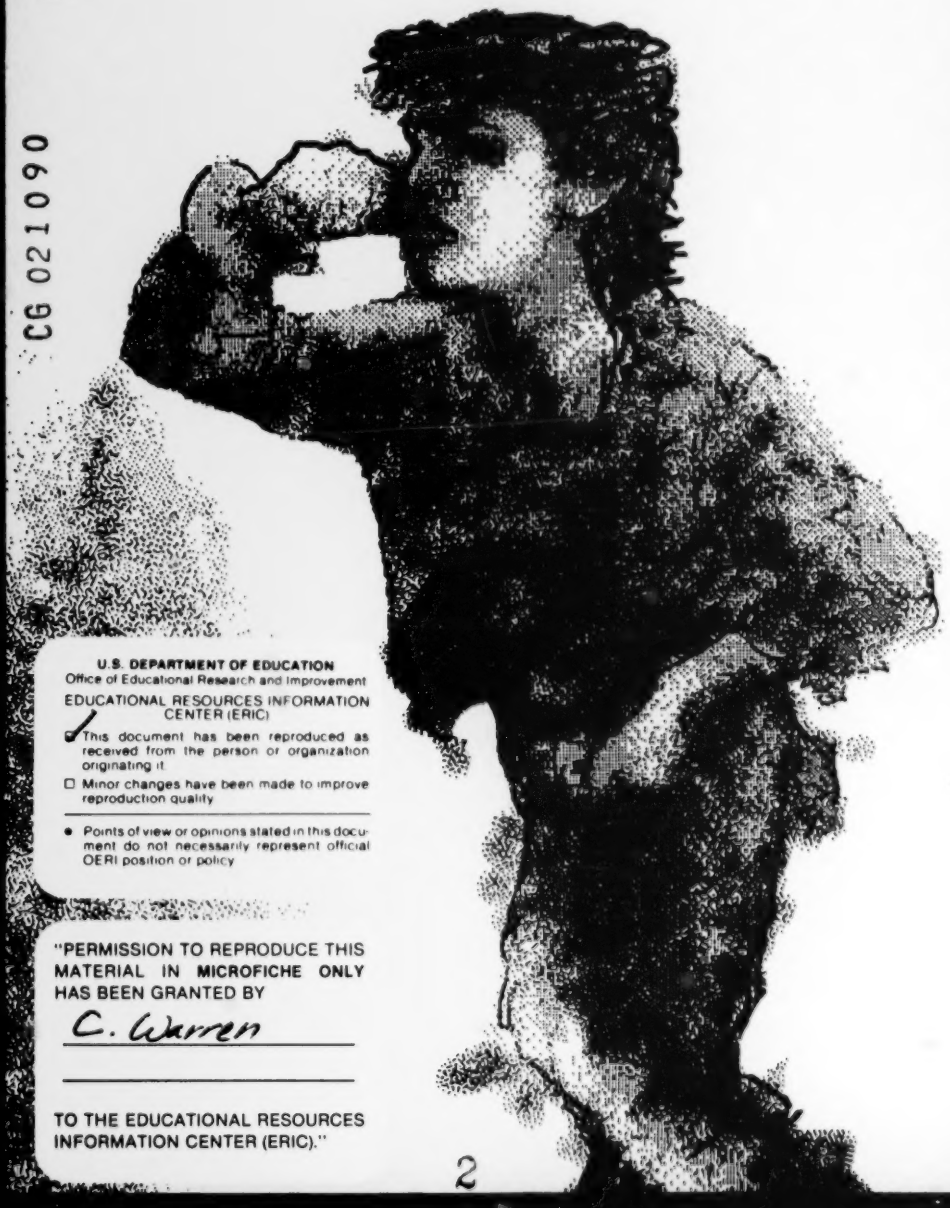
Restoring the Kin Network



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Adolescents and Suicide

Restoring the Kin Network

by Steven E. Gutstein
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Foreword

On an average day in America, more than a dozen adolescents will end their own lives. The loss of the potential of these youngsters overshadows even the pain and suffering experienced by those they leave behind.

Many of these children grew up in a familial system which provided them little or no support during the most turbulent period in their lives. Recognition of the importance of family and kinship support led clinicians at the Houston Child Guidance Center to implement a new and radically different type of treatment. This new service, called the Systemic Crisis Intervention Program or SCIP, is based on the premise that children need a healthy kin system to serve as a buffer to the all too frequent crises of adolescence. This type of support system is missing in many families, and SCIP rebuilds functioning systems by involving kin. In some cases more than two dozen family members and relatives are brought together—some from as far away as New York—to help a troubled teenager.

A follow-up study was conducted, examining the outcome for forty-seven suicidal adolescents served by the program during its initial years. The study showed conclusively that SCIP is a success—providing appropriate management of the immediate crisis while reconstructing a kinship support system to prevent the reoccurrence of suicidal behavior.

The traditional treatment for many suicidal children is commitment to a psychiatric institution, an expensive and not always successful course of action. It was not without risk that the Houston Child Guidance Center undertook the development and implementation of a new and initially controversial program to help troubled adolescents. Their courage resulted in an effective alternative for Houston's children and families in crisis.

Ralph E. Culler III
Executive Associate
Hogg Foundation for Mental Health

Introduction

"Childhood constitutes the happiest time of life."

"Youth is wonderful—carefree and delightful."

"Would that I were young again."

Everyone has heard similar statements. Literature often portrays the happiness of childhood and the delights of adolescence. Famous artists have painted joyful young people. Magazines and television frequently show families around holiday tables, laughing together or talking earnestly.

Why, then, is reality at times so far different from the portrayals in the various media? Why, between 1960 and 1980, did the suicide rate for 15- to 24-year-olds rise more than 230 percent? What has caused suicide to be second only to accidents as the leading cause of death among young Americans?

In this country, in one year, approximately 5000 young people take their lives. Where is the discrepancy between the fictional loving family and joyous childhood and the reality of despairing young people who see no possible outlet except suicide?

Let's ask Mark. He's in the lunchroom at the junior high school. You can almost pick him out. He is sitting by himself, a 13-year-old whose dark hair hangs over his forehead. His eyes never look up, and his shoulders droop. He eats steadily, seemingly without relish. He talks with no one and no one talks with him.

On second thought, don't bother to ask Mark anything. He will just look down at his scuffed shoes and reply in monosyllables. Mark feels disconnected from family, from friends, from life. The only firm avowal he has made recently is that he plans to kill himself, to emulate his paternal uncle who has succeeded in a recent suicide attempt. Mark has frequent visions that his uncle is extending an invitation to join him in heaven. He has also had visions of his father's committing suicide at his uncle's grave site.

He is consumed with thoughts of death. If he were dead, he wouldn't have to face the math test on Friday—or, more importantly, the kids on the bus or in the lunchroom. Mark has no place to take his feelings. His mother and sister live in another city. His father has not been around much since the divorce when Mark was three. Aunt Tillie and Uncle Joe, with whom he lives, are absorbed with their own jobs and children.

No one, it seems, has room or time for Mark.

Or,—we could find out how Tammy feels. She is in the back of the English classroom at the nearby high school. Tammy, trim, blonde, green-eyed, would be pretty if her mouth didn't turn down or her eyes didn't have dark circles around them.

She pays little attention to what the teacher is saying. Perhaps she is thinking about the trip to the hospital night before last. It all seems like a dream. She and Tim had sat in his car, quarreling bitterly. Now she could not remember what had been so important or what had made her so angry that she returned the bracelet he had given her and told him it was over.

What she can recall is the feeling of total loss when she finally went into the house, past her mother's bedroom, and threw herself on her bed. No one came to her, not her mother who was so preoccupied with Tammy's little sister and stepfather that she never seemed to notice if Tammy was around or not. Nobody cared about her, no girl friends, no boyfriend, no family.

That's when Tammy remembered the pills the doctor had given her after she had her wisdom teeth pulled. Lots of pills were left. Tammy decided, quickly, that she wanted this loneliness over with fast. She got a glass of water from the kitchen, took the bottle into her bedroom, and swallowed the tablets one by one. She turned the radio on and listened to music until she got sleepy—so sleepy. She'd never be lonely again. . . .

Tammy could not fathom where she was when she next opened her eyes. The woman in white was definitely not an angel. Then she saw her mother looking worried. Little by little she recognized the hospital room. Someone had found her. She was not dead—just alive and very much alone.

She lay quietly, wondering how life would have been for her if her father had not died in a boating accident two weeks before she was born. Her grandparents had taken her in because her mother had seemed

unable to look after her. All was okay for the first five years. But when her mother had given birth to an illegitimate child, everyone noticed the new baby and forgot Tammy. Then her mother remarried. She and the new husband, along with the two daughters, moved 500 miles away. From then on, Tammy had felt totally forgotten.

Now she is back in school. Alone and miserable.

Mark and Tammy and teenagers like them are the reasons for the Systematic Crisis Intervention Program. A multidisciplinary team at the Houston Child Guidance Center, recognizing the vital role of kin relationships, developed the project. Since researchers found that the type of relationships that endure over time and that lead to the greatest support are those developed with kin, the team brings in the families. Included are members of the nuclear and extended family such as parents, siblings, uncles, aunts, grandparents, cousins, in-laws, as well as close enduring family friends who, over the years, come to be "honorary" kin.

Many researchers have demonstrated that a healthy kin system is crucial in order for members of the family to adapt successfully to major life transitions. Without strong kin relationships, the nuclear family is at great risk for those transitions to turn into life-or-death crises. The Systemic Crisis team—made up of psychologists, social workers, psychiatrists, and counselors—works with the adolescent, family, and friends to develop a ceremony of reconciliation in which all members can experience their strength and unity as well as the family's capacity to adapt to meet the unique needs of the individuals.

The importance of reintroducing the suicidal adolescent to his or her kin and of parents' acknowledging that they cannot cope alone has been seen firsthand. A powerful effect has been witnessed as family members return to examine the extremes of the past that resulted in isolation and polarization. By coming together with their mutual loss, family members can reunite through a sense of shared grief over the family strengths they so much wanted and never had.

The Systemic Crisis Intervention Program was developed to be an effective outpatient-based response during the suicidal crisis period. It is not meant to be an alternative to the post-crisis psychotherapy often necessary to treat effectively these seriously disturbed children and adolescents.

What Propels the Young to Suicide?

Available evidence suggests that those who attempt or commit suicide tend to come from multiproblem families, have a long history of personal problems, and usually have made several unsuccessful efforts to communicate their distress before resorting to an attempt or actual suicide.

National statistics become all the more wrenching when one considers that both suicide attempts and completions are significantly underreported. A number of researchers note that mortality data contain intentional cover-ups by physicians or family members or misclassification as accidental death when evidence of suicide is insufficient. It has been suggested that a more accurate picture might be revealed by multiplying given statistics two- or maybe threefold.

It has also been estimated that there may be as many as 10 to 60 suicide attempts for each recorded death. Most researchers agree that attempted suicide rates are *at least* ten times higher than those of completed suicides in most groups. However, professionals emphasize the conservative nature of this estimate, stating that the figure in America is more likely in the range of 250,000 to 500,000 nonfatal suicide attempts per year for 15- to 24-year-olds. By any standard, youth suicide is one of the most pressing problems facing today's mental health professionals.

Researchers and theorists have long talked about the important role of the social network in preventing suicide. Social isolation has been singled out as a crucial variable that greatly increases the risk of suicide. Emile Durkheim, the father of the discipline of suicidology, has stated that "suicide varies inversely with the degree of social integration of the individual."* Numerous studies have shown that suicidal people tend to be socially isolated and have few meaningful social contacts. People who are able to develop a number of close, reciprocal relationships in which there is an emotional give-and-take have been found to be at very low risk for suicide.

* Durkheim, Emile (1951). *Suicide*. Glenco, Ill.: Free Press.

It is known that suicide most often occurs around times of major developmental transitions in people's lives—such as reaching adolescence or adulthood—when persons must reformulate their self-concepts and redefine familial and societal roles. In addition, they must be able to replace or renegotiate the relationships that have been crucial to them. One way of thinking about the role of social networks in suicide is that the presence of a number of relationships tends to make developmental periods less traumatic.

Certainly becoming an adolescent entails different changes. The adolescent needs a great deal of support during this period. The type of support needed is not always straightforward. Those close to the teenager must balance between giving freedom and maintaining supportive control.

The family is probably the most important source of social support for any individual. Family conflict is the most frequently cited reason given by adolescents for their suicide attempts. Additionally, altered family functioning has been mentioned as the most significant factor in determining the effectiveness of treatment with a suicidal adolescent.

Many experts believe that the nuclear families of suicidal adolescents do not have the emotional resources necessary to carry out successfully the tasks required by major developmental transitions. It appears that these families are unable to provide the teenagers with the type of support that they need during this difficult period.

These families tend to be highly vulnerable, with a high rate of divorce and parent loss. Parents in these families are also more likely to be suffering from depression and alcoholism. In many cases the families have actually lost the ability to get the support they need from extended family members and close friends. In other words, the families of suicidal adolescents have become isolated from the relationships needed to help people adapt to the stresses and crises of life.

Take Mark, for example . . .

Let's follow Mark home from school. His books are slung over his shoulder in a bag which is never opened at home. No one seems to care if he studies or not. Certainly his aunt and uncle aren't concerned, and his mother never writes or asks him about school when she calls.

Sometimes he worries about Mom and thinks about the days when he took care of her because his stepfather threatened to kill them all. Then he got shipped off to the aunt's house, maybe for keeps. He sees his real dad from time to time. But Dad now has cancer, and when they are together, he seems to want Mark to comfort him instead of the other way around.

Experience with families of suicidal adolescents has taught that these youth become isolated from their kin and close relationships because of a long history of painful events in these families. From their own earlier childhood, parents often recall feeling rejected, abandoned, or trapped in relationships. They often felt they were sacrificing their own needs for those of others, seeing themselves as "survivors" of toxic family situations from which they escaped. Individuals from families like this tend to marry people with similar feelings and rely on only a few people to meet all of their needs. Their children, like Mark and Tammy, then grow up in an atmosphere of social isolation. They know few of their relatives. They have few intimate relationships and little or no sense of belonging to a kin system or sense of heritage.

As these families become isolated from close relationships, they have great difficulty handling any new separation and loss. Their own family experiences lead them to believe that love is difficult to obtain and once it is lost it cannot be replaced. Children growing up in these isolated families tend to develop the belief that intimate relationships can only be "exclusive." That is, the children believe that if family members have relationships outside the immediate circle, love is taken away from them—they perceive a betrayal.

Isolated families tend to have a history of broken relationships; when separations occur, people simply do not get back together. For the child the experience is that, over time, there are fewer and fewer people to rely upon. Therefore, significant relationships are seen as "irreplaceable"—if love is lost, a void is left forever. In isolated families, members believe that relationships have to be held onto at any cost.

Mark's Family

Mark's history of isolation from his kin system went back several generations. Over the years, numerous crises had disconnected them. The first major blow occurred with the death of Mark's grandmother when Tommy, her son, was nine months old; she was just 19. Tommy's father abandoned his two young sons shortly after his wife's death. The sons lived with relatives and had no further contact with him.

When Tommy was a young child, his uncle committed suicide. This had the effect of keeping family members distanced—holding themselves outside the reach of repetition of such a painful loss. Tom had almost no contact with his extended family while growing up. Two decades later Tom and Linda, now parents of Mark, divorced. This was a bitter divorce and, for several years, Mark did not get to see his father.

Mark grew up knowing very little about his family history. He had little contact with his father's family after his parents divorced; even prior to the divorce there was no contact with most of them. His mother rarely took him to visit her parents or her sisters, even though they lived in the same city. Linda's father was an alcoholic who was never available for her emotionally. Her mother spent many years caring for her own bedridden mother and never seemed to have time for the children. Linda learned early on that you took care of yourself unless you were sick. What Mark did know of family was that people often left you and never returned and that once you lost a relationship, you could never replace it. The one relative Mark had been close to, his uncle Sammy, he had lost ten days ago in a way that led Mark to distrust any other kin involvements.

Mark was in a severe emotional bind. He was feeling an extremely high level of hurt and pain; yet he was afraid to let anyone in emotionally, afraid really to depend upon the people who were there for him. Mark believed in the exclusivity of love. He felt that if he allowed himself to acknowledge the love of his uncle, aunt and cousin, he would lose the relationship with his mother. He also believed in irreplaceability—that if he lost the relationship with his mother, there would never again be anyone who could love him in the way that he needed.

Tammy's Family

Tammy grew up never having known her father or any of his family. His relatives blamed her mother for his death and chose to cut off relationships with her and her children after the funeral. On the other side, Tammy's experience of her mother's family was of having kin around her and then losing them. With her mother's remarriage, their move to Houston, and the death of her grandfather, Tammy lost the relationships that had been most important to her. Feeling that her mother was preoccupied with other family members, Tammy sought to replace the special relationship she had had with her grandfather by becoming involved with older men. Each relationship left her feeling used and empty. Her persistent violation of her mother's rules in dating these men separated Tammy more and more from her mother. Tammy had lost the one relationship she had counted on. Now she feared that she had broken familial connections and would never be accepted back.

Where Are the Healing Forces?

Strong families are good suicide deterrents. Several aspects of a healthy functioning kin system are the following:

—Kin play a loss-buffering role.

For example, the death or illness of a parent or a polarizing divorce need not leave the child dependent upon only one person for all of his or her needs.

—Kin provide for the diffusion of intimacy.

Though certain relationships retain their primary importance to the child, no one relationship is experienced as providing for all of one's needs so there is not a resulting unhealthy level of dependency.

—Kin act as natural conflict mediators.

Relatives can provide a "cooling off" place to avoid a feeling of being boxed in with no place to go, which is usually a precipitant of extreme actions. They can serve as neutral mediators who can introduce objectivity into a problem. Similarly, kin can provide the setting and the impetus to "bury the hatchet" and resolve long-standing feuds.

—Kin provide a sense of belonging.

Kinships provide the strength of knowing that one belongs to a unit larger than any one relationship. Relationships may be gained and lost, people may feud, but whatever else happens, one can still retain his or her membership and sense of heritage in the kin system.

Rationale for the Systemic Crisis Intervention Program

The intervention is based on four beliefs regarding the effective treatment of suicidal children and adolescents:

1. Dependency on institutions is to be avoided. Studies have demonstrated that a reliance on hospitalization can create an "institutional dependency." Rather than learning to cope with crises by using their own natural resources, families too often rely on institutions when their children's behavior precipitates a crisis.

2. Altering the functioning of the nuclear and extended family and natural network of the patient is essential.

3. Utilizing the crisis precipated by the suicidal behavior as an opportunity for growth and change is important. The SCIP program emphasizes the importance of not buffering the crisis and thereby ending the opportunity it affords. Hospitalization typically communicates to parents that the child is being taken care of by experts. This message may lead to a premature termination of family members' sense of crisis and thus a decrease in both their involvement and their motivation to seek change.

4. Addressing accurately the risk of suicide while developing safe emergency responses capable of minimizing this danger is crucial. The hospital is an obvious setting for maintaining the safety of the adolescent during the suicidal crisis. However, SCIP experience has demonstrated that family members, if suitably instructed and if 24-hour backup is available, can safely monitor a child's behavior during a period of suicidal crisis without the detrimental effects of institutionalization. Throughout the process, by a combination of daily telephone contacts and direct visits, the patient is continually monitored to ascertain the dangerousness of his or her condition.

Suicidal behavior is a shock to family members, and it may serve to loosen previously rigid family behavior patterns. This period of increased openness, so characteristic of crises, is often only temporary. Following this critical period, the earlier patterns of rigidity in functioning will reemerge. In order to capitalize on this opportunity, clinicians respond rapidly and intensively. They are careful to control their emergency response so that it is intensive enough to create a safe situation but not so intensive that it removes altogether the family's sense of crisis or urgency.

The danger of the suicidal crisis must be addressed equally with the opportunity for change. Therefore, the Systemic Crisis Intervention Program emphasizes the rapid, intensive assessment of the child's suicidal risk and recognizes the necessity of providing emergency responses when needed. A comprehensive system of emergency options is available to the clinicians including brief hospitalization, day treatment, and medication.

The Treatment Model

Treatment involves three components: (1) providing an immediate emergency response which serves to maintain family members' anxiety within manageable limits, (2) mobilizing extended family members to become involved around the crisis, and (3) restructuring kin system relationships to provide successful long-term solutions to the current crisis.

The clinical team is typically contacted through phone calls from a variety of referral sources. Cases are screened immediately over the phone by trained crisis clinicians. Plans are made for emergency responses as necessitated on a case-by-case basis. A three-hour evaluation is conducted by two members of the crisis team staff within 24 hours of the initial call. During this evaluation, decisions are made following consideration of five factors determining the dangerousness of the patient's behavior:

Any prior history of suicidal behavior or thinking,

The patient's and parents' current affective and mental status,

The lethality of the attempt,

The specificity of plans for future suicidal actions,

The degree to which the suicidal behavior has elicited a sense of crisis in at least some family members.

Subsequently, clinicians meet individually with family members to prepare them for upcoming family gatherings. Two critical tasks during this period include inviting the patient's extended family members to the meetings and developing the process of multiple advocacy. Typically, family members of suicidal children are so polarized that a single therapist alone cannot gain the trust of all members and adequately represent their needs. A crisis team has been developed with multiple therapists. From the beginning of treatment, each team member takes an advocacy position to represent the needs and dilemmas faced by one of the centrally involved family members.

After several hours of preparation, therapists typically conduct two four-hour meetings attended by the nuclear and extended family members. The purpose of these gatherings is to foster a process of

reconciliation among family members that can be used to prevent future extreme reactions to stresses and developmental transitions.

Following crisis treatment, which typically lasts from two to six weeks, families are referred for some type of continued outpatient therapy which usually involves a combination of family and group therapy.

Crisis Intervention with Mark's Family

The first response following an evaluation that Mark's behavior posed a serious suicide threat was to have the family institute a 24-hour-a-day home suicide observation of Mark. If the family had been unable to have someone stay with Mark during this dangerous period, placement in a psychiatric hospital would have been recommended. Several family members including Mark's mother, father, stepmother, uncle, aunt, sister, and cousin took part in this observation.

While the suicide watch was under way, the crisis team met with individual family members to prepare for the upcoming family meetings. Members of the team spent several hours learning the important stories of both parents and extended families, as well as developing trusting relationships with family members.

Two four-hour crisis sessions were held with the family and kin. During the meeting Mark's father, Tommy, was able to show that, though he was often ill, he could still be a source of support to his son. Linda was able to resolve much of her conflict with her ex-husband as well as confirming for Mark that he would not be permanently living with his aunt and uncle. Both Tommy and Linda were able to recognize the need for and request the support of their kin. Tommy appointed Mark's uncle as Mark's "second father" to be available when Tommy was too ill. Linda acknowledged her sense of isolation and the need to feel closer to her three sisters and mother. While Mark did not get to return immediately to his mother, he was able to remain with his aunt and uncle knowing that he could utilize their support without risking the loss of his mother and sister.

Crisis Intervention with Tammy's Family

As with Mark's family, Tammy's relatives took time from their jobs and other responsibilities to share in a 24-hour suicide watch until the time of the first crisis meeting.

Also in a similar manner, the crisis team met with the key family members to build alliances and to learn the family stories of events that had led to so much conflict and polarization among kin. The struggles went back generations; so, too, must the solutions. Tammy's grandmother was invited and she attended the first gathering, but years of hurt could not be reconciled during one afternoon. The older mother and daughter—Tammy's mother, Paulette—remained angry and in conflict after the meeting.

During the second meeting, Paulette's two sisters were invited to see if they could provide a family link for Paulette during the time it would take to rebuild her relationship with her mother. The three sisters were able to share secrets about the family that each knew and had never told the others —secrets that had kept them apart in the past. Together they grieved and mourned for the family connectedness they had missed. They emerged from the meeting with a new sense of unity and support. Tammy's stepfather, Tom, had also become isolated from any family relationships. During this same meeting, Tom was able to reach out to his brother, Larry, from whom he had cut off contact five years ago.

Tammy was able to share her fears that she would no longer be accepted into the family. She was able to obtain a sense that, no matter what, she would remain a member of her kin and would deserve the love of her family.

The Study

In an effort to assess the clinical effectiveness and safety of Systemic Crisis Intervention, a large number of treated adolescents and their families were studied. They were followed for up to a year-and-a-half after treatment, with periodic measures being taken regarding family and marital functioning and the adolescents' behavior.

Not all children and adolescents who demonstrated suicidal behavior had been seen as appropriate for the intensive outpatient response provided by the program. Calls to Houston Child Guidance Center were initially screened by trained intake workers who decided on the severity and urgency of the case. If the case was not deemed of a crisis nature, it was referred for a more appropriate treatment modality such as family, group, or individual therapy. Only the most serious cases were referred to the intervention program.

When cases reached the clinicians, they were subjected to a second screening in order to determine the appropriateness of using this intensive modality. Three specific criteria were used to ascertain a family's suitability for treatment:

—A potentially lethal suicide attempt and/or clear and convincing threats to commit suicide,

—A recommendation for psychiatric hospitalization from a medical or mental health professional or a serious consideration of hospitalization by parents,

—Family members' high level of disturbance over the suicidal behavior to the extent that they were willing to mobilize the necessary resources for treatment.

Forty-seven of the first 81 suicidal children and adolescents evaluated met the above criteria. Because of low lethality of suicidal behavior, lack of prior history of self-destructive acts or thoughts, and/or the lack of future suicidal ideation, 13 youths were judged not to be in danger severe enough to warrant an intervention this intensive; instead, they were referred for family therapy. In five cases, parents refused treatment and their children were referred for hospitalization. In an additional three cases, the combination of high lethality and low parental concern

led to hospitalization. Thirteen families were able to resolve the crisis during the evaluation process and were referred for outpatient psychotherapy.

Of the 47 children and adolescents accepted for treatment, 21 had made actual attempts involving drug overdoses or swallowing of potentially lethal substances. Twenty-six had not made a recent suicide attempt but were continuing to voice serious threats of suicide including clear plans about methods, timing, and place.

Description of the Youth Studied

Adolescents in the study were 22 boys and 25 girls ranging in age from 7 to 19, with a mean of 14.4 years. Five were black, twelve Hispanic, twenty-nine white, and one was Oriental. Seventeen were living with both biological parents. Sixteen were from single-parent families in which the parents were divorced or separated. Eleven subjects were in a household which included one biological parent and a stepparent. Finally, two were living with a single parent who was a widow or widower, and one was with adoptive parents. Household incomes ranged from less than $12,000 to well over $50,000 annually.

How Safety and Effectiveness Were Measured

Included among the measures used to assess the clinical effectiveness of the intervention program were three parent ratings and two measures of patient behavior. Parents rated the severity of the child's problem and family and marital functioning on simple rating scales ranging from one to either five or seven (problem severity, 7-point; family and marital functioning, 5-point). The number of problem episodes the child experienced were monitored using an extensive 46-item problem checklist. The list included such severe problems as depressive episodes, severe anxiety, psychotic behavior, conduct violations, violent actions, property destruction, substance abuse, running away, school failure, and sexual promiscuity. Adaptive behavior was meas-

ured by means of a 23-item behavior scale which addressed issues of school, family, social, and interpersonal functioning on the part of the patient.

Measures were taken during the family's initial intake evaluation, and follow-up interviews were conducted at 3 months, 6 months, and at a point between 12 and 18 months. During brief follow-up interviews, parents rated three items: (1) the severity of the problem which precipitated treatment, (2) marital and family functioning, and (3) adaptive behavior on the part of their children. In addition, they identified the number of problem episodes each child experienced since the last contact, noted information concerning the status of ongoing treatment, detailed any institutional measures taken, and described any suicidal or other crisis behavior exhibited by the child.

Results

Treatment Effectiveness and Safety

Of the 47 children and adolescents involved in this study, only two engaged in suicidal behavior during the follow-up period of more than one year. In both cases the behavior occurred within six months of treatment, and in neither case was there serious physical harm. One attempt involved minor drug ingestion and the other superficial cuts on the wrist. There were no suicide attempts during treatment. Additionally, there were no reports of injury to either the identified patient or family members during the treatment phase or follow-up period.

Although 87 percent of parental ratings described the presenting problem as "severe" or "catastrophic" at the outset of treatment, only a small minority were rated as such following treatment. Ratings improved markedly after 3 months, with only 27 percent indicating that the crisis had, for the most part, not been resolved. This trend continued, and more than 12 months later, parents indicated their children had improved significantly, frequently describing the problem as "minimal." Only 12 percent of patients indicated that the problem remained severe more than 12 months after treatment.

In an effort to check for the possibility of "crisis substitution," a process by which the resolved crisis is simply replaced by a new one, a problem checklist was used to monitor the frequency of occurrence of a wide range of problem behaviors. The number of problem episodes did not increase following treatment. On the contrary, a significant decrease was witnessed over the next months.

Ratings of family and marital functioning, as well as adaptive behavior on the part of the patient, reflect the overall effectiveness of the Systemic Crisis Intervention Program. Prior to treatment only 6 percent of parents described their families as functioning in the "well" to "very

well" range. Similarly, only 34 percent of parents reported that their marital relationship was functioning well prior to treatment. Both ratings consistently improved during the next year and a half. More than 12 months after treatment, 63 percent of parents described their families, and 58 percent their marriages, as functioning in the "well" to "very well" range. Adaptive behavior measures also demonstrated gradual improvement during follow-up. The children's behavior was rated as significantly better more than 12 months following treatment.

Institutional Use Following Treatment

Of the 47 children and adolescents treated and followed, only one required any institutional contact after treatment. Another measure of the program's effectiveness at reducing institutional dependency can be made by using these families, in a sense, as their own controls. Rates of institutional placements of identified adolescents were compared for more than a year's period both before and following treatment in the Systemic Crisis Intervention Program. Ten of the total sample of 47 youths had been in an institutional setting during the 12 months prior to intervention. By comparison, only the one required hospitalization or residential placement during the follow-up period.

Limitations and Strengths of the Study

The current study is only a preliminary attempt at investigating the viability of mobilizing kin systems as effective means of coping with adolescent crises. It is not without major limitations. Among the criticisms to be directed at this work are the following:

• Although results clearly attest to the safety and effectiveness of Systemic Crisis Intervention, no control or comparison group was used. A more rigorous experimental design would require random selection of families for either intervention treatment or psychiatric hospitalization, a difficult if not impossible design to implement.

• As with all follow-up studies, the simple availability of families for follow-up somewhat biases the sample in terms of treatment success. In other words, the more cooperative and available the family is for contact and follow-up, the more successful the intervention is likely to appear.

• The sample is self-selected in that they were families that, while not actively seeking an outpatient alternative to hospitalization, did not reject the opportunity for the crisis intervention treatment.

• There is a need to extend both the length and breadth of follow-up. Families need to be followed for as long as five to ten years, and a larger sample of adolescents with psychotic symptomatology and primary substance abuse problems should be evaluated. Each one of these points represents issues that should be addressed in future research.

The current study also has several strengths. Among them, the repeated measures design employed demonstrates that the program does not serve just as a psychological band-aid in times of crisis but yields stable change. Although future crises will undoubtedly occur in these families, the Systemic Crisis Intervention Program has enabled them to develop new coping styles for dealing with situations by noninstitutional means.

Limitations of Intervention

The Systemic Crisis Intervention Program was not successful for all families. As noted, one adolescent was in an institutional setting 18 months following treatment. The use of SCIP may be contraindicated in certain situations, such as when evidence exits of clear-cut psychotic symptoms, heavy institutional involvement, or the lack of parental urgency following extreme life-threatening behavior. Hospitalization or some other institutional placement may be necessary in these situations. It was not expected that successfully treated clients would require no further intervention or have no further problems. While problems do remain following treatment, the data demonstrate that they are much less likely to be solved by the use of an institutional solution.

Although the results of this study lend preliminary support to the efficacy of mobilizing kin systems as a successful intervention in child and adolescent suicidal crises, they in no way portray the extent to which the therapists were impressed by the willingness and ability of the great majority of family members to assume a major role in the treatment process when empowered by professionals. For example, many parents took off a week or more from work with little advance notice to ensure the safety of their children during the initial acute crisis period. Equally impressive was the response of close family and friends. Relatives who had been out of contact for years became actively involved in the crisis, as family members often traveled great distances to participate.

The current study sets the stage for future research by demonstrating that many severely suicidal children and adolescents can be safely treated in an outpatient setting when family members are able and willing to mobilize the necessary resources.

Conclusion

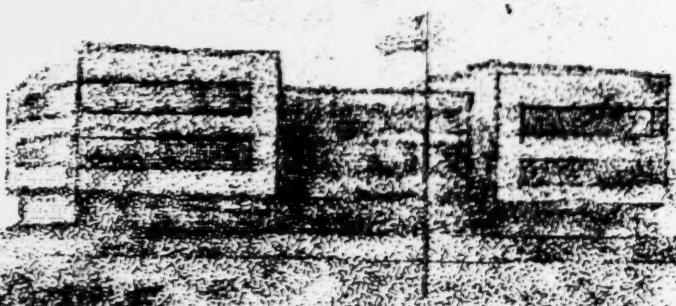
Mark and Tammy are working through their crises. They bear scars, but they have supportive extended family to help them.

Strengthening adolescents' ability to meet life is a task of paramount importance. The Carnegie Corporation of New York, a major philanthropic foundation, has recognized this fact which was delineated in a report from Carnegie President David A. Hamburg:

> There is not the slightest reason to believe that today's young people are less talented or resourceful than were their predecessors; but if they are to learn to survive, flourish, and create, we have to understand the circumstances, tasks, and obstacles they face better than we now do. Such understanding can help us to help young people formulate useful strategies for coping with the world transformed—and in so doing can perhaps assist us in shaping a more humane and compassionate society.*

*Hamburg, David A. (1986) *Preparing for Life: The Critical Transition of Adolescence*. New York: Carnegie Corporation.

23



31